TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SCOTT & WHITE SURGICAL

Respondent Name
ARCH INSURANCE COMPANY

MFDR Tracking Number
M4-17-1989-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 28, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Respondent has failed to either submit reimbursement or denial for the above services."

Amount in Dispute: $1,595.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charges are disputed as this is a controverted claim. We have attached the EOB as well as the PLN-1 that supports this."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2016	Outpatient Hospital Services	$1,595.70	$1,570.66.

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.2 defines terms related to medical billing and processing.
2. 28 Texas Administrative Code §133.240 sets out procedures for medical bill payments and denials.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
5. Texas Labor Code §408.027 sets out provisions regarding payment of health care providers.

6. The explanation of benefits submitted by the respondent is dated bill review date March 9, 2017 with post date March 16, 2017. It was issued by the insurance carrier *after* the filing of the medical fee dispute request (which was received by the division on February 28, 2017). 28 Texas Administrative Code §133.307(d)(2)(F) requires that the response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. As the submitted EOB was presented to the requestor *after* the MFDR request was filed, any new denial reasons or defenses contained in the EOB have been waived, and shall not be considered in this review.

Issues

1. Did the insurance carrier timely pay, reduce, deny or take final action on the services in dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor contends that "The Respondent has failed to either submit reimbursement or denial for the above services." for the disputed services.

   Texas Labor Code Sec. 408.027(b), requires that:

   > The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim.

   Corresponding Rule §133.240(a) requires that:

   > An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

   Final action on a medical bill is defined in 28 Texas Administrative Code §133.2(6) as:

   (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement . . . and/or
   (B) denying a charge on the medical bill.

   While the respondent submitted a copy of an EOB processed and issued after the filing of the request for MFDR, no information was found to support that the insurance carrier took final action or issued EOBs in accordance with the requirements of 28 Texas Administrative Code §133.240 (a) and (e).

   Rule §133.307(d)(2)(B) states that the respondent shall provide "a paper copy of all initial and appeal EOBs related to the dispute . . ."

   The respondent did not present any EOBs issued prior to the filing of the request for MFDR. The response included a copy of a plain language notice to the injured employee indicating denial of compensability/liability for an on the job injury. However, no information was submitted to support that this information had ever been given to the health care provider.

   Rule §133.240(a) requires that:

   > An insurance carrier shall take final action after conducting bill review on a complete medical bill . . . not later than the 45th day after the insurance carrier received a complete medical bill.

   Rule §133.240 (e)(1) requires that the insurance carrier shall send the explanation of benefits in accordance with the elements required by Rules §133.500 and §133.501. The explanation of benefits shall be sent to: "the health care provider when the insurance carrier makes payment or denies payment on a medical bill . . ."

No documentation was presented to support that the insurance carrier took final action on the disputed services in accordance with the requirements and time limits prescribed by division rules.

All workers' compensation insurance carriers are expected to fulfill their duty to take final action as required by law and the division's administrative rules. The insurance carrier failed to do so in this case.

Rule §133.307(d)(2)(F) requires that:

> The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The insurance carrier's failure to take final action or issue explanations of benefits to the health care provider constitutes grounds for the division to find a waiver of defenses at Medical Fee Dispute Resolution.

The respondent submitted an explanation of benefits processed on March 9, 2017—after the filing of the request for MFDR. In accordance with Rule §133.307(d)(2)(F), the newly raised defenses and denial reasons shall not be considered in this review.

As no information was presented to support that the insurance carrier had provided to the requestor any denial reasons or defenses in regard to the disputed services during the bill review process, prior to the filing of the MFDR request, the division finds the respondent has waived any such defenses. The disputed services will therefore be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount (including outlier payments) applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Separate reimbursement for implantables was not requested.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

3. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 23350 has Medicare payment status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
   - Procedure code 73040 has status indicator Q2, denoting conditionally-packaged codes; reimbursement is packaged with payment for any service with status indicator T. As there were no T status codes billed, this line is separately payable and is assigned status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. The service is assigned APC 5524. The OPPS Addendum A rate is $351.71. This is multiplied by 60% for an unadjusted labor-related amount of $211.03, which is multiplied by the facility wage index of 0.9572 for an adjusted labor amount of $202.00. The non-labor related portion is 40% of the APC rate, or $140.68. The sum of the labor and non-labor portions is $342.68. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount for this line of $342.68 is multiplied by 200% for a MAR of $685.36.

- Procedure code 73222 has status indicator Q3, denoting conditionally packaged codes that may be paid through a composite APC (if OPPS criteria are met). As no other composite services were billed, this line is eligible for separate payment and is assigned status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. The service is assigned APC 5582. The OPPS Addendum A rate is $454.32. This is multiplied by 60% for an unadjusted labor-related amount of $272.59, which is multiplied by the facility wage index of 0.9572 for an adjusted labor amount of $260.92. The non-labor related portion is 40% of the APC rate, or $181.73. The sum of the labor and non-labor portions is $442.65. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount for this line of $442.65 is multiplied by 200% for a MAR of $885.30.

4. The total recommended reimbursement for the disputed services is $1,570.66. The insurance carrier has paid $0.00 leaving an amount due to the requestor of $1,570.66. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,570.66.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,570.66, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 26, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.